**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

TEXAS INSTITUTE FOR SURGERY
C/O ADVANCED PRACTICE INC
17101 PRESTON ROAD SUITE 180 S
DALLAS TX 75248

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

**Respondent Name**
ZURICH AMERICAN INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M4-09-7524-01

**MFDR Date Received**
APRIL 10, 2009

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The guidelines states that the reimbursement calculation shall be Medicare facility-specific amount, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors, as published annually in the Federal Register. The OPPS allows reimbursement via the Ambulatory Patient Classification (APCs). Reimbursement is to be at 200% of the Medicare facility specific rate."

**Amount in Dispute:** $1,049.93

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Reimbursement for these services was made pursuant to the provisions of 28 TAC 134.403 and the applicable Medicare maximum allowable reimbursements. No additional reimbursement is owed for this service date."

**Response Submitted by:** Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| May 30, 2008 | Outpatient Hospital Services | $1,049.93 | $1,039.24 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the

reimbursement for guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 10, 2008 and March 5, 2009
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup.
   - 494 – Hospital outpatient allowance was calculated to Medicare's Methodology plus a markup per the Texas OMFS.
   - 618 – The value of this procedure is included in the value of another procedure performed on this date.
   - 626 – The non-facility portion has already been processed. This allowance is for the facility portion.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - W1 – Workers Compensation State Fee Schedule adjustment.

**Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

**Findings**

1. Review of the submitted documentation finds no information to support a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code C1769 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to §134.203, the Medical Fee Guideline for Professional Services. The fee listed for this code in the applicable Medicare fee schedule is $10.86. 125% of this amount is $13.57. The recommended payment is $13.57.
   - Procedure code 25606 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 62, which, per OPPS Addendum A, has a payment rate of $1,666.18. This amount multiplied by 60% yields an unadjusted labor-related amount of $999.71. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of $978.31. The non-labor related portion is 40% of the APC rate or $666.47. The sum of the labor and non-labor related amounts is $1,644.79. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.353. This ratio multiplied by the billed

charge of $3,658.75 yields a cost of $1,291.54. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $1,644.79 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $1,120.07. The allocated portion of packaged costs is $1,120.07. This amount added to the service cost yields a total cost of $2,411.61. The cost of this service exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers and any multiple procedure discount, is $1,644.79. This amount multiplied by 200% yields a MAR of $3,289.57.

- Per Medicare policy, procedure code 93005 is included in, or mutually exclusive to, another code billed on the same date of service. Separate payment is not recommended.

4. The total recommended payment for the services in dispute is $3,303.15. This amount less the amount previously paid by the insurance carrier of $2,263.91 leaves an amount due to the requestor of $1,039.24. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,039.24.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,039.24, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | August 22, 2012 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.